STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 120114-001**

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _20th_ day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 17, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on March 24, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Flexible Blue II Individual Market Certificate* and the related *Rider HCR-IB-PCB2 (Health Care Reform-Individual Business-Preventive Care Benefits).* The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On January 11, 2011, the Petitioner underwent a colonoscopy at XXXXX Hospital. BCBSM provided coverage for the procedure, but allocated $1,710.05 to the Petitioner's deductible which is BCBSM's approved provider payment. Neither party submitted any medical records related to the colonoscopy. BCBSM submitted an explanation of benefits (EOB) form for the Petitioner's anesthesia and pathologist's tissue examination, however no EOB form was submitted for the colonoscopy procedure.

The Petitioner appealed BCBSM's application of a deductible for the procedure. BCBSM held a managerial-level conference on February 26, 2011, and issued its final adverse determination dated February 28, 2011.

III. ISSUE

By assessing a deductible, did BCBSM correctly process the Petitioner's colonoscopy claim?

IV. ANALYSIS

Petitioner's Argument

In her request for review, the Petitioner wrote:

> I had a colonoscopy on 1-11-11. It's suppose to be a preventative screening covered by BCBSM. Because there were findings: polyps removed & biopsied, claim was rejected.
>
> How can a colorectal screening be complete without checking the findings?

BCBSM's Argument

BCBSM stated that it imposed the deductible requirement because the colonoscopy was not a screening procedure but rather was billed as a "medical colonoscopy." According to BCBSM, the procedure code submitted by the Petitioner's physician was "45380 Colonoscopy with biopsy . . . with the diagnosis code 211.3 [benign neoplasm of the colon]."[1]

BCBSM does not dispute that the colonoscopy was necessary. However, in its final adverse determination BCBSM's representative wrote:

> Your coverage also includes *Rider HCR-IB-PCB2* . . . Under that rider, we pay for one routine screening colonoscopy performed by a panel or nonpanel provider once per member per calendar year. This service is not subject to any deductible or copayment requirements. But as you and I discussed during your conference, *even though colonoscopy services are scheduled as routine screening, if complications arise then the services become medical and are subject to any deductible and coinsurance requirement under the contract.* This appears to be what occurred in your case. Your doctor removed tissue for biopsy and billed for a medical colonoscopy with biopsy. [Emphasis added.]

1 In its April 4, 2011 position paper, BCBSM indicated that the colonoscopy was a "virtual colonoscopy" (also known as a "computed tomographic colonography"). However, the procedure codes for a virtual colonoscopy are in the 74000 – 74190 series. Based on BCBSM's assertion that Petitioner's doctor used code 45380, it does not appear the Petitioner had a virtual colonoscopy.

Commissioner's Review

The Petitioner's colonoscopy benefit is described in *Rider HCR-IB-PCB2*. This rider was created by BCBSM, according to the rider's cover page, "to add coverage for additional immunizations and preventive care benefits as required under the Patient Protection and Accordable Care Act" (PPACA). The rider provision related to colonoscopies provides:

> Facility and professional benefits for colonoscopy services are payable as follows:
>
> - We pay for one routine screening colonoscopy performed by a panel or **nonpanel** provider once per member per calendar year. This service is not subject to any deductible or copayment requirements.
>
> – Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and copayment requirements.

In this case, BCBSM has added an additional condition, not included in the certificate or rider, by which BCBSM can change the billing status of a colonoscopy based on the results of that procedure. In effect, BCBSM has written out of its required coverage the benefit for a preventive colonoscopy without copayment. Not only is BCBSM's policy inconsistent with the certificate, rider and the PPACA, but it is also contrary to BCBSM's own guidelines published in its newsletter to providers.

BCBSM's *HealthReform* newsletter[2] provides health care professionals with information about health care reforms required by the PPACA. The December 10, 2010, issue details the preventive health services BCBSM members can receive with no cost-sharing:

> Under the Patient Protection and Accordable Care Act, your Blue Cross Blue Shield of Michigan and Blue Care Network patients have full coverage for the preventive services listed here. . . . .
>
> Preventive services are covered with no member cost-sharing when a member uses a participating or in-network provider, and when *the main purpose of the office visit is to receive preventive care.* . . . (Emphasis added.)

Additionally, an "alert for health care professionals and facilities" providing various preventive service procedure codes with no member cost-sharing was issued by BCBSM on January 3, 2011, in its *HealthReform* newsletter. Among the services listed is 45380, the procedure code the Petitioner's doctor used to document her colonoscopy. As the *HealthReform*

2 http://www.bcbsm.com/healthreform/pubs/provider_flier_preventive_final.pdf

material states, there is no cost-sharing "when the main purpose of the office visit is to receive preventive care." It is the purpose of the testing, not the results of the testing that determine whether cost-sharing is required.

Based on BCBSM's own representation of its preventive services cost-sharing, it is clear that there is no cost-sharing requirement for a colonoscopy under the Petitioner's circumstances.

The determination of whether or not a colonoscopy is a "routine screening colonoscopy" should be based on the reason for performing the procedure, not on an after-the-fact evaluation of the results of the colonoscopy. The Petitioner indicated that her doctor only recommended this procedure because of her age. BCBSM does not dispute the Petitioner's claim that the procedure was scheduled as a preventative screening. The Petitioner had no symptoms which might have caused her physician to order the procedure to diagnose a medical problem. These factors support the conclusion that the procedure was a routine screening colonoscopy.

The Commissioner finds that BCBSM must process the claims as a routine screening colonoscopy and not apply any cost-sharing requirement such as deductibles or copayments.

V. ORDER

BCBSM's final adverse determination of February 28, 2011, is reversed. BCBSM is required to provide coverage without cost-sharing for the colonoscopy provided on January 11, 2011. BCBSM shall reprocess this claim within 60 days of the date of this Order and shall, within seven (7) days of providing coverage, provide the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding its implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner